HEALTH IMPROVEMENT ACTIVITY IN RURAL DEVELOPMENT PROGRAM COUNTIES - SECOND PROGRESS REPORT

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The Rural Development Program was outlined in the first progress report of health work in Rural Development Counties published in March 1957. 1/ This program was initiated to help low-income farm families attain an improved level of living and a more satisfactory life. The key units in the program are the county committees, made up of leaders in farming, business, civic and church affairs, with government agencies cooperating. Committee members direct surveys to gain information on resources, plan and publicize development projects, and help coordinate the work being done by agencies and organizations taking part in the program. This report summarizes the work accomplished and planned in pilot counties in connection with health improvement.

Need for health improvement in Rural Development Program pilot counties and areas is demonstrated by the higher infant mortality rates and lower level of health resources which characterize these areas as a group in comparison with the total counties of the United States (see Table, p. 5). The infant mortality rate is about one-fifth higher than the United States rate; local per capita expenditures for organized public health services are less than half the average for all counties covered by such services; and both public health and other health personnel -- doctors, dentists, and nurses -- are in short supply as compared with all the Nation's counties.

Twenty local Rural Development Program committees have health subcommittees. In addition, other RDP localities have committee members who work with State and local agencies to bring about (1) needed improvements in sanitation, (2) new medical facilities, (3) additional health personnel, (4) increased use of public health services, (5) better diets at home through the school lunch programs, and (6) health education. The following sections set forth examples of action taken in Rural Development Program counties.

1/ This report was issued by the U. S. Department of Agriculture, Agricultural Marketing Service, Farm Population and Rural Life Branch.

Sanitation

Twenty-seven pilot counties have made improvements in sanitation or are planning to work on problems of this nature. Among the improvements made or planned are: (1) Water analysis to insure a pure water supply, (2) garbage disposal control to prevent dumping along the highways, (3) clean-up campaigns, (4) sewage systems for county seat towns, and (5) insect and rodent control.

Medical Facilities

Several pilot counties obtained help through the Hospital Survey and Construction Program for financing the construction of hospitals and health centers. Bonds were floated to build a new 69-bed hospital at Jessup, Wayne County, Georgia. Choctaw County, Oklahoma, voted a bond issue to help finance a 32-bed general hospital and health center at Hugo; the hospital has been completed and another wing for children is planned.

The Grainger County (Tennessee) officials appropriated $14,400 for the county's share of a $60,000 health center to be built at Rutledge. Funds are being raised in Price County, Wisconsin, to build a new hospital.

Each pilot county in Kentucky (Butler, Elliott, and Metcalfe) succeeded in raising $5,000 for the matching of Federal aid for a new health center. According to reports from Kentucky, all three counties were unable to achieve this goal before the Rural Development Program committees were organized.

Health Personnel

A major goal in a number of pilot counties is to obtain additional health personnel. Reports from the counties state: "Health department is understaffed," "county sanitation is needed," "no health units nor school nurses," "shortage or complete lack of physicians in certain areas," and "dental correction program for indigent school children is needed."

Examples of work already done are indicative of what can be accomplished. In order to attract another physician, the people of Twiggs County, Georgia, built a modern 9-room brick and tile office and residence and offered free rent for six months. Three physicians were considering this location when this report was submitted. The health committee in Taney County, Missouri, helped to obtain a nurse for the county schools.

Some areas are taking steps to supplement the efforts of professional health workers. For example, in cooperation with local home demonstration clubs and the Red Cross, the health, education and

welfare committee in Watauga County, North Carolina, has arranged for a Red Cross instructor to give a course in home nursing. "Each enrollee is expected to teach the course to at least thirty others in her community."

The Cherokee County, Oklahoma, committee reports that vocational education personnel worked out a training program for practical nurses with the cooperation of the local hospital. This will give local high school graduates and older women a chance to obtain training that had not been available previously.

Public Health Services

Many pilot counties report a marked increase in the use of public health services. The Rural Development Program committee in Santa Fe County, New Mexico, reports that more people are using the local clinics now than formerly. Hardin County, Tennessee, indicates that "50 percent more children are having pre-school examinations."

Residents of pilot counties are supporting immunization programs, particularly against poliomyelitis. Franklin Parish, Louisiana, held the county's first poliomyelitis immunization clinic for the 20 to 40 age group. In Guernsey County, Ohio, poliomyelitis shots were given to pre-school children as well as adults. Negro children in Covington County, Mississippi, and members of underprivileged families in Bamberg County, South Carolina, were receiving the shots. Houston County, Tennessee, led the State for several months in percentage of population immunized against poliomyelitis.

Nutrition

Rural Development Program committees obtained help from various agencies in efforts to improve the nutritional level of local families. Home demonstration groups and extension agents encouraged the planting of gardens, the preservation of food, and the planning of well-balanced meals. Boards of education have backed county committee recommendations regarding support of school lunch programs.

Committee reports indicate the seriousness of nutritional problems in certain RDP counties. In Hardin County, Tennessee, where 95 percent of the children are transported by school buses, a survey showed that 45 percent of the pupils leave home without breakfast. As a result of this discovery, a school breakfast program was carried out in three schools and improvement was noted as follows: Pupils who were served breakfast in this program had fewer colds and headaches, improved attitudes, and their discipline problems decreased.

Other localities report:

(1) Plans to serve fruit juice in the rural schools in Grainger County, Tennessee, because many pupils come to school without breakfast.

(2) Emphasis on school lunch programs by the health and nutrition committee in Raleigh, West Virginia.

(3) Work by the committee for improved family living in San Augustine-Shelby Counties, Texas, on nutrition problems in cooperation with the home economics teacher. The teacher held a frozen-foods workshop in three schools.

(4) Visit by a health worker to Wautauga County, North Carolina, to assist homemakers in menu planning.

Health Education

Success in health education can be measured in part by the support of local people for local health programs. Surveys to obtain needed facts about the situation proved an effective educational device for local cooperation and support for improvements in some areas.

In Perry County, Indiana, a health survey that covered the entire county was preceded by the training of more than 200 local people as interviewers. The survey was planned under the cooperative leadership of the State Board of Health and the Agricultural Extension Service. Local home demonstration clubs and other extension groups worked with the county health council to carry out the survey.

The Hardin County (Tennessee) health department, working with community development organizations, made health surveys in four communities. These studies developed awareness of the need for a school lunch program.

Six pilot counties in Texas conducted surveys that gave each family an opportunity to list its problems. Health problems were listed more frequently than any others. On the basis of the facts obtained, programs were instigated to raise nutritional levels, improve sanitary conditions, promote immunization against poliomyelitis, and initiate many other health measures.

The health and nutrition committee in Santa Fe County, New Mexico, held seminars in all communities of the county to acquaint people with the nutrition and health needs revealed by a local survey.

In many Rural Development Program counties, local people are kept informed about health problems through radio programs, news articles, meetings of local organizations and informal groups, and personal contact with workers in the local health departments and health committees. The subcommittees on health have a special responsibility to disseminate facts about health. Informing the people of the parish about services and programs is one of the goals listed by the subcommittee on health, education and welfare in Avoyelles Parish, Louisiana.

Comparison of Rural Development Program Pilot Counties and Areas With Total Counties of the United States as to Income, Infant Mortality, and Selected Health Resources

Item	102 Counties involved in Rural Development Program 1/	3067 Counties of United States
1. Per Capita Income, Estimated, 1956 . .	$1,232	$1,681
2. Infant Mortality Rates (deaths under 1 year of age per 1,000 live births), 1954	31.0	26.6
3. Number of counties included in areas covered by full-time organized public health services, 1956 2/	89	2209
4. Per capita expenditures for full-time organized public health services in areas having such services, 1956 3/		
Total from all sources	$.70	$1.20
Total from local sources	.34	.88
Total from State sources	.27	.25
Total from Federal sources	.09	.07
5. Health department personnel per 100,000 population in areas served by full-time organized public health services, 1956 4/		
Physicians	.7	.9
Public health nurses	5.9	8.5
Sanitation personnel	2.9	5.2
6. Beds in general and allied special hospitals per 1,000 population, 1956 5/		
Total beds	2.5	4.1
Acceptable beds	2.1	3.7
7. Private dental, medical, and nursing personnel per 100,000 population, 1950		
Physicians and surgeons	58	127
Dentists	23	50
Professional nurses	110	264
Practical nurses	47	90

1/ There are 62 single counties and 9 areas in the Rural Development Program. The 9 areas include 40 counties. A total of 102 counties are involved.

2/ In some cases, the local health jurisdiction providing full-time organized public health services is a single-county unit corresponding to a Rural Development Program pilot county. In other cases, the local health jurisdiction is a State or local health district including two or more counties, one of which is a pilot area for the Rural Development Program.

In a few Rural Development Program counties and areas, separate city health jurisdictions serve a population center within a county. Data for these city units were excluded.

3/ Six of the counties having organized public health services did not report per capita expenditures. If the county was part of a multi-county unit, the population covered by the entire unit was used in calculating per capita expenditures.

4/ As with expenditures, personnel-population ratios were calculated, using the population covered by an entire local health jurisdiction, whether it covered one or more than one county.

5/ Twelve Rural Development Program pilot counties had no general hospital within the county in 1956. These counties are served by hospitals in nearby counties.

The total bed-population ratios include both acceptable and non-acceptable beds. The term "nonacceptable" refers to beds classified thus by State agencies on the basis of fire or health hazards or other substandard conditions.

Sources:

Item 1. Sales Management, "Survey of Buying," May 10, 1957.

Item 2. Vital Statistics of the United States, 1954, Vol. 1, table 18.

Items 3, 4, and 5. Division of General Health Services, U. S. Public Health Service. County population data used in calculations for Items 4 and 5 are estimates of the Public Health Service as of January 1, 1957, which allow for probable gains or losses in population since the 1950 Census.

Item 6. Division of Hospital and Medical Facilities, U. S. Public Health Service. Data are from 1957 and 1958 State plans.

Item 7. Division of Public Health Methods, U. S. Public Health Service: Health Manpower Source Book, Section 4, County Data. (Data prepared as a special tabulation from the 1950 Census of Population.)

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